attach patient label here

Methodist Le Bonheur Healthcare

Physician Orders ADULT

Order Set: ABVD

Diagnosis : Hodgkins Lymphoma

Height: _____cm Weight: _____kg			Cycle: _____ Of :_____
Actual BSA: _____m2 Treatment BSA: _____m2			Day/Wk: _____ Freq: _____
Allergies:	[ ] No known allergies		
[ ]Medication allergy(s):_____			
[ ] Latex allergy [ ]Other:			
Vital Signs			
[ ]	Vital Signs	T;N, q15 min for 1 hour, Comment: once bleomycin test dose has been administered	
Patient Care			
[ ]	Nursing Communication	T;N, Do not exceed a treatment BSA of _____ m2	
[ ]	Nursing Communication	T;N, May hold hydration during chemotherapy infusion	
[ ]	Nursing Communication	T;N, Verify patient has had MUGA or ECHO to r/o Cardiac dysfunction prior to chemotherapy	
Medications			
[X]	EPINEPHrine 1:1000	1mg/mL , Injection, IV Push, (for 1 dose) , PRN bleomycin reaction	
Pre Medications			
NOTE: Administer the below TEST DOSE before the first dose of bleomycin			
[X]	bleomycin	2 units, IV, IV Push, TEST DOSE , Wait a minimum of 1 hour before administering the remainder of dose	
CHEMOTHERAPY			
	Drug(generic) & solution (optional)	**Intended Dose**	**Actual Dose**	**Route, Infusion, Frequency and total doses**
[X]	**DOXOrubicin**	**25 mg/m^2**		**IV Push, Once on DAYS 1 and 15**
[X]	**bleomycin**	**10 units/m^2**		**IV Piggyback, Infuse over 60 min, Once on DAYS 1 and 15**
[X]	**vinBLAStine**	**6 mg/m^2**		**IV Push, Once on DAYS 1 and 15**
[X]	**dacarbazine**	**375 mg/m^2**		**IV Piggyback, Infuse over 60 min, Once on DAYS 1 and 15**
Acute Emesis Prophylaxis (may undergo therapeutic interchange)			
NOTE: Administer intial doses at least 30-60 minutes prior to chemotherapy			
[X]	ondansetron	12 mg, Injection, IV Piggyback, qDay, on DAYS 1 and 15	
[X]	dexamethasone	12 mg, Injection, IV Piggyback, qDay, on DAYS 1 and 15	
[X]	prochlorperazine	10 mg, Tab, PO, q6h, PRN Nausea/Vomiting	
[X]	prochlorperazine	10 mg, Injection, IV Push, q6h, PRN Nausea/Vomiting , Comment : if unable to take PO	
Consults/Notifications			
[ ]	Notify Physician- Once	T;N, Who: _____, For: if BSA exceeds 2 m^2	
[ ]	Notify Physician- Once	T;N, Who: _____, For: hypotension, dyspnea and O2 saturation less than 92%	

_____ _____ _____ _____

Date **Time** **Physician's Signature** **MD Number**